

<b>Case Number:</b>	CM14-0108544		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	12/04/2005
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 54-year-old female who reported an injury on 12/04/2005. The mechanism of injury was not provided. On 04/09/2014, the injured worker presented with significant discomfort. Upon examination there was decreased cervical extension, upper extremity motor and sensory exams were grossly intact and there was reasonable range of motion with a negative Slocum and impingement test. The diagnoses were right shoulder pain secondary to C5 to C6 and C6 to C7 radiculopathy. Previous treatment included an H-wave therapy and Percocet for pain. The provider recommended a cervical epidural steroid injection and a right shoulder injection, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**One cervical epidural injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection, page 46 Page(s): 46.

**Decision rationale:** The California MTUS Guidelines recommend epidural steroid injection as an option for treatment of radicular pain. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehabilitation efforts, including home exercise. There is no information on improved function. The criteria for use of an epidural steroid injection include radiculopathy, and must be documented by a physical examination and corroborated by imaging studies; be initially unresponsive to conservative treatment; injections should be performed using fluoroscopy; and no more than 2 nerve root levels should be injected using transforaminal blocks. The clinical note revealed upper extremity and motor sensory grossly intact and reasonable range of motion with negative impingement test. There was lack of evidence of radiculopathy documented by the physical examination and corroborated by imaging studies. There is also lack of documentation of the injured worker's initial unresponsiveness to conservative treatment, which would include exercises, physical efforts and medications. Additionally, the provider's request does not indicate the use of fluoroscopy for guidance and it does not indicate the levels of which the epidural injection is indicated for in the request as submitted. As such, the request for 1 cervical epidural injection is not medically necessary.

**One right shoulder injection (therapeutic steroid injection):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The California MTUS/ACOEM Guidelines state invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and critical steroid preparation may be indicated after conservative therapy for 2 to 3 weeks. The evidence supporting such an approach is not overwhelming. The number of injections should be limited to 3 per episode, allowing for assessment of benefit between injections. There is lack of evidence of a failure to respond to conservative therapy. Additionally, an adequate examination of the injured worker was not provided detailing current deficits to warrant a steroid injection. As such, the request for 1 right shoulder therapeutic steroid injection is not medically necessary.